ZYPREXA ZYDIS
MEDICAL NECESSITY INFORMATION SHEET

With Few Exceptions Approval If Granted Is For 3 Months

DATE OF REQUEST:_____

FIRST REQUEST FOR ZYPREXA ZYDIS? [ ] Yes [ ] No

Patient's Name:_____Pt's 9 Digit IDPA#:_____

Patient's SSN:_____Diagnosis:_____Requested Daily Dose:_____Mg.

Facility:_____Facility Phone #:_____

Will Administration of <u>Each Dose</u> of Zyprexa Zydis Be Done By Caregiver? ( )Yes ( )No

If No How is Compliance Assured?_____

PATIENT'S CLINICAL STATUS: (Circle Degree of Severity)
Paranoid: + + + + Catatonic: + + + + Agitated: + + + +

INDICATION FOR ZYPREXA ZYDIS:

Organic Dysphagia [ ]

Oral Aversion To <u>All</u> Medications: Refusal [ ] Cheeking [ ] Spitting [ ]

_____DEA # _____ Phone #_____
Physician's Name (Please Print)

_____ _____
Physician's Signature OR Nurse's /P.A's Signature For Dr.

PHARMACY NAME & PHONE NO._____

INFORMATION MUST BE COMPLETE OR FORM WILL BE RETURNED

PLEASE FAX TO: MEDICAL COMMITTEE 217-524-7264

THIS INFORMATION IS CONFIDENTIAL AND FOR USE ONLY BY IDPA PERSONNEL INVOLVED IN THE PRIOR APPROVAL PROCESS **Revised 10/15/2003**